STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445239	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MORGAN COUNTY	419 SOUTH KINGSTON STREET WARTBURG, TN 37887

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor fire doors were only held open by approved devices. The findings include: 1. Observation and interview with the Maintenance Director, on 9/29/2015 at 11:17 AM confirmed the corridor fire doors by room 201 had one side that would not close to a positive latch. 2. Observation and interview with the Maintenance Director, on 9/29/2015 at 11:35 AM confirmed the corridor fire doors by the rehab department had one side that would not close to a positive latch. These findings were verified by the Maintenance Supervisor and acknowledged by the	K 021	Life Care Center of Morgan County is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility works in cooperation with the State of Tennessee department of Health toward the best interest of those who require the services we provide. While this plan in not to be considered and admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted September 28 thru September 30, 2015. This Plan of Correction is the facilities with Federal and State requirements. Oct. 26, 2015 K 021 1. What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice? The Maintenance Director has adjusted the fire doors located in the corridor by rooms 201 and the rehab department to automatically close to a positive latch. This was completed on 9/30/2015. 2. How will you identify other residents having the potential to be affected by the same deficient practice? The Maintenance Director will examine construction of the building to ensure that all fire doors are positively latching when fire alarm has been sounded. This is done on a monthly bases.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
B Lett/A	Executive Director	10/15/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 021	Continued From page 1 Administrator during the exit conference on 9/29/2015.	K 021	3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or maintenance assistant will conduct a monthly fire drill to ensure our facility maintains the fire doors are positively latching. 4. How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous area doors closed to a positive latch. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: Observation and interview with the Maintenance Director, on 9/29/2015 at 11:35 AM confirmed corridor doors to central supply room failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 029		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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K 021	Continued From page 1 Administrator during the exit conference on 9/29/2015.	K 021		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous area doors closed to a positive latch. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: Observation and interview with the Maintenance Director, on 9/29/2015 at 11:35 AM confirmed corridor doors to central supply room failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 029	K029 1. What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice? The Maintenance director has adjusted the door to central supply to assure closer to a positive latch. This was completed on 9/30/2015. 2. How will you identify other residents having the potential to be affected by the same deficient practice? The Maintenance Director will examine construction of the building to ensure that all fire doors are positively latching when fire alarm has been sounded. This is done on a monthly bases. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or maintenance assistant will conduct a monthly fire drill to ensure our facility maintains the fire doors are positively latching.	Nov. 2, 2015
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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K 021	Continued From page 1 Administrator during the exit conference on 9/29/2015.	K 021	4. How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous area doors closed to a positive latch. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: Observation and interview with the Maintenance Director, on 9/29/2015 at 11:35 AM confirmed corridor doors to central supply room failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 029		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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K 052	Continued From page 2 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire alarm system.(NFPA 72) The findings include: Observation during a fire drill with the maintenance director on 9/29/15 at 11:18 AM confirmed a trouble light on the fire alarm panel and the strobes failed to flash upon fire alarm activation. Interview with the maintenance director on 9/29/15 at 11:18 AM confirmed he was aware of the strobes not working. to maintain the fire alarm system. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 052	K 052 1. What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice? The Maintenance Director along with the contracted Sprinkler Company (CBS) will replace the part of the fire system that controls the strobes. This work is scheduled for 10/21/2015. 2. How will you identify other residents having the potential to be affected by the same deficient practice? The Maintenance Department will continue to examine the system to assure all working properly at all times. CBS will do their routine checks to assure all is working properly also. The maintenance department will do monthly and as needed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or maintenance assistant will conduct a monthly audit for 3 months to ensure our facility system is functioning properly.	Oct 26, 2015
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		

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K 052	Continued From page 2 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire alarm system.(NFPA 72) The findings include: Observation during a fire drill with the maintenance director on 9/29/15 at 11:18 AM confirmed a trouble light on the fire alarm panel and the strobes failed to flash upon fire alarm activation. Interview with the maintenance director on 9/29/15 at 11:18 AM confirmed he was aware of the strobes not working. to maintain the fire alarm system. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 052	4. How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits reviewed for 3 months or until 100% compliance is achieved. K 062	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062	1. What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice? The Maintenance Director along with the sprinkler company has audited all	Nov. 2, 2015

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K 062	Continued From page 3 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the sprinkler system. The findings include: Observation with the maintenance director on 9/29/15 between 9:00 AM and 3:00 PM, revealed the following; 1. One tarnished sprinkler head in the dishwasher room. (NFPA 25, 5.2.1.1.1) 2. One of one sprinkler head in the cooler was covered with lint and foreign material. (NFPA 25, 5.2.1.1.1) 3. One sprinkler head in the shower room across from 208 was covered with foreign material. (NFPA 25, 5.2.1.1.1) 4. One sprinkler head in the laundry was covered with foreign material. (NFPA 25, 5.2.1.1.1) 5. In the secure unit storage room, a sprinkler escutcheon has moved and is now obstructing the deflector. 6. An escutcheon is missing in the freezer. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 062	sprinkler heads throughout the building. Planes to replace head in dishwasher room will be accomplished on October 27th, 2015. All lint and foreign material has been removed with all sprinkler heads. All escutcheons have been checked and replaced if needed. All has been completed by October 27, 2015. 2. How will you identify other residents having the potential to be affected by the same deficient practice? Maintenance Department will examine all sprinkler heads to ensure that all are clean from any paint, lint, dust or debris to assure proper working order is obtained. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or maintenance assistant are conducting a bi monthly audit and cleaning all routinely to assure compliance and all are in proper working order. 4. How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place?	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069		

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K 062	Continued From page 3 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the sprinkler system. The findings include: Observation with the maintenance director on 9/29/15 between 9:00 AM and 3:00 PM, revealed the following; 1. One tarnished sprinkler head in the dishwasher room. (NFPA 25, 5.2.1.1.1) 2. One of one sprinkler head in the cooler was covered with lint and foreign material. (NFPA 25, 5.2.1.1.1) 3. One sprinkler head in the shower room across from 208 was covered with foreign material. (NFPA 25, 5.2.1.1.1) 4. One sprinkler head in the laundry was covered with foreign material. (NFPA 25, 5.2.1.1.1) 5. In the secure unit storage room, a sprinkler escutcheon has moved and is now obstructing the deflector. 6. An escutcheon is missing in the freezer. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 062	The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069	K 069 1. What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice? The Maintenance Director has installed a cable that will restrict movement to prevent the flexible gas line from overextending. This was completed on October 5, 2015.	Oct. 16, 2015

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K 069	Continued From page 4 Based on observation and interview, the facility failed to ensure commercial cooking equipment producing steam or grease-laden vapors were located under a commercial hood.(NFPA 96) The findings include: Based on observation and interview, the facility failed to ensure commercial cooking equipment complies with NFPA 54. The finding includes: The natural gas oven, double steamer and fryer were on casters and their movement was not restricted to prevent the flexible gas line from overextending. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 069	2. How will you identify other residents having the potential to be affected by the same deficient practice? The cable has been permanently place so removal cannot be accomplished. All other equipment is secured. All equipment has been assessed to verify that it is secured permanently in place to prevent movement by the maintenance director. This was completed by the maintenance director. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or assistant maintenance will review monthly to assure cable is properly placed. 4. How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee includes the Executive	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire resistance of fire barriers and communicating openings. (NFPA 101 2000 Edition Section 8.3.5.1, 19.1.1.1.2, 19.1.1.4.1, 19.1.1.4.2) Findings include: Observation and interview with the Maintenance Director, on 9/29/2015 at 10:40 AM, confirmed the kitchen's 1-hour rated ceiling was improperly	K 130		

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K 069	Continued From page 4 Based on observation and interview, the facility failed to ensure commercial cooking equipment producing steam or grease-laden vapors were located under a commercial hood.(NFPA 96) The findings include: Based on observation and interview, the facility failed to ensure commercial cooking equipment complies with NFPA 54. The finding includes: The natural gas oven, double steamer and fryer were on casters and their movement was not restricted to prevent the flexible gas line from overextending. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 069	Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire resistance of fire barriers and communicating openings. (NFPA 101 2000 Edition Section 8.3.5.1, 19.1.1.1.2, 19.1.1.4.1, 19.1.1.4.2) Findings include: Observation and interview with the Maintenance Director, on 9/29/2015 at 10:40 AM, confirmed the kitchen's 1-hour rated ceiling was improperly	K 130	K 130 1. What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice? The Maintenance director has installed patch work that meets the 1 hour rated materials on the ceiling. This was completed on 10/12/2015. 2. How will you identify other residents having the potential to be affected by the same deficient practice? The Maintenance Director will examine construction of the building to ensure all ceilings meet the 1 hour rated ceiling. This is done on a monthly bases.	Nov. 2, 2015

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K 130	Continued From page 5 patched in several locations with a non-rated, non-listed fiberglass reinforced panel (FRP). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 130	3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or maintenance assistant will do a walk through assessment with the Executive Director monthly to assure our facility maintains compliance.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met ~~as~~ evidenced by: Based on observation and interview, the facility failed to ensure medical devices were plugged directly into a wall receptacle. (NFPA 99, 3-3.2.1.2 (d) (2). The findings include: Observation and interview with the Maintenance Director, on 9/29/2015 at 11:07 AM confirmed the use of a power strip in resident room 206 with one (1) power strip with a medical device plugged into it. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 147	4. How will the corrective action be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? The Maintenance Director or maintenance assistant will report findings of the audit to the interdisciplinary PI committee for 3 months or until 100% compliance is achieved. The Performance improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of the audit. If deemed necessary by the committee, the process will be evaluated/revised and /or the audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445239	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MORGAN COUNTY	419 SOUTH KINGSTON STREET WARTBURG, TN 37887

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K 130	Continued From page 5 patched in several locations with a non-rated, non-listed fiberglass reinforced panel (FRP). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 9/29/2015.	K 130	reviewed for 3 months or until 100% compliance is achieved.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445239	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/28/2015

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